CONTENTS

SECTION 1. DEFINITIONS

Some words or phrases used in this booklet may not be familiar to you; however, they have a very specific meaning when applied to MAP. To help you understand how MAP works, it is important for you to know what the following terms mean as used in this booklet.

Alternate Benefits. Certain expenses covered by MAP that must be pre-certified by QCP. Alternate Benefits are designed to provide you with options to hospital stays and other medical care or treatments. Alternate Benefits include coverage for:

- Birthing centers/nurse midwives
- Extended care/skilled nursing facilities
- Home health care
- Hospice care
- Partial hospitalization for a substance abuse rehabilitation program
- Expenses due to special arrangements or treatments when medically appropriate
- Private duty nursing

Ambulatory Surgical Facility. An institution, either free-standing or a part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures where a patient is admitted and discharged within a brief period (generally not exceeding 24 hours).

The following <u>are not</u> considered ambulatory surgical facilities:

- An office maintained by a physician or group of physicians for the practice of medicine, or a surgical suite as part of their office
- An office maintained for the practice of dentistry
- A facility primarily engaged in performing abortions

Appeal. A written request mailed within 100 days after receipt of notification of the Review decision regarding any denied claim (either in whole or in part) or other disputed matter (see Section 17).

Birthing Center. A facility used for the normal delivery of children, operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Carve Out. When MAP is the secondary plan, the Claims Administrator determines the charges covered under MAP and subtracts the payment that would have been made by the primary plan, whether or not the eligible participant is enrolled in the primary plan (see Sections 12 and 13).

Claims Administrator. An organization that processes medical claims at the request of the Company. The Claims Administrator for MAP is Blue Cross and Blue Shield of Alabama.

Claims Report. A statement provided by Blue Cross and Blue Shield of Alabama that describes the status of a claim. It includes information such as which expenses MAP covers, applies to the deductible, pays, or excludes. Many medical plans refer to this report as an "Explanation of Benefits" or "EOB".

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, signed into federal law April 7, 1986. COBRA requires that group health coverage be continued under certain circumstances when coverage otherwise would end or change (see Sections 15 and 16).

Coordination of Benefits (COB). COB applies when a participant is eligible for coverage under two or more group health plans. COB laws and MAP provisions determine which plan must consider the expenses first. That plan is called the PRIMARY plan. The plan that considers expenses after the primary plan is called the SECONDARY plan. There is no COB between BellSouth companies covered under MAP, nor does MAP coordinate benefits with any HMO.

Copayment. The dollar amount a participant pays when using various programs, e.g., Mail Order Prescription Drug Program, PPO physician office services, etc.

Cosmetic Surgery. Any surgical procedure that primarily improves or changes appearance but does not primarily improve bodily functions or correct deformities resulting from disease, trauma, or congenital anomalies. Improvement of bodily function does not include improvement of psychological effects caused by physical defects or conditions. Cosmetic surgery is not covered under MAP.

Covered Charge/Covered Expense. The charge associated with a covered medically-necessary service, supply, or procedure incurred by a participant for a non-occupational illness or injury, that is eligible for consideration based on Reasonable and Customary (R&C) limits, Payment Allowance limits, or Negotiated Fees established under MAP and not excluded by any other provision of MAP. For example, amounts above R&C limits are not covered expenses.

Custodial Care. Care primarily for the purpose of providing room and board (with or without routine nursing care, training in personal hygiene, other forms of self-care or supervisory care by a physician) for a person who is mentally or physically disabled. Custodial care is not covered by MAP.

Deductible. The amount of covered expenses you pay during the calendar year before MAP will begin paying benefits. The deductible will be applied in the order in which claims are processed by the Claims Administrator. The individual deductible is $165 and applies each calendar year to you and each of your covered dependents. For example, you have $200 of covered generic prescription drug expenses to be filed under MAP and have not filed any other claims during the calendar year. The claim will be processed as follows:

Covered Charges:	$200
Less Calendar Year Deductible:	$165
MAP Pays	$ 31.50 ($35 x 90%)

The family deductible will be met when covered charges applied toward your deductible and/or other family members' individual deductibles total $400, or when two $165 individual deductibles have been met, whichever occurs first.

Dependent. A family member who qualifies for MAP coverage by meeting the following criteria:

- **Class I Dependents.** Your spouse and your unmarried children living with you, until the end of the year in which they reach age 19 or age 23, if they are enrolled as full-time students, or an unmarried child who is physically or mentally disabled and fully dependent on you for support. In order to remain a Class I dependent, a child must be classified as disabled before losing Class I status by reaching the age of 19, or 23 if a student.

  If a Class I dependent child is certified as disabled, he/she will continue as a Class I dependent as long as he/she qualifies as disabled (regardless of age) as described on page 8.

  For divorce situations, contact your Benefit Office.

Children include your own children, legally adopted children, stepchildren or children for whom you or your spouse are permanent legal guardians, if they live with you. Temporary guardianship does not qualify for eligibility. Wards of the state, foster children and/or custodial appointments are not included.

- **Class II Dependents.** Your unmarried children (other than Class I dependents), your unmarried grandchildren, your unmarried brothers/sisters, and your or your spouse's parents and grandparents if they have lived with you or in a household owned, leased, or rented for them by you in the vicinity for at least six months before applying for coverage.

  Vicinity means the same town or city and Zip Code area as your residence or within a distance where you can provide daily care and supervision of the dependent. However, a full-time student who has attained age 24 or older and satisfies the income and Class II dependency requirements, does not have to live in the vicinity.

  To qualify for coverage, the total income of a Class II dependent (not including any support you provide) must be less than $8,800 from all sources, including Social Security, during the calendar year in which he/she is covered.

- **Sponsored Child.** An unmarried child, age 19 or older, who is not a full-time student. You may sponsor such a child for coverage until the end of the year in which he/she reaches age 23, whether or not the child resides with you and regardless of his/her income. You must pay the full cost of this coverage. To apply, contact your Benefit Office.

Durable Medical Equipment (DME). Equipment approved by the Claims Administrator as medically necessary to diagnose or treat an illness or injury, to improve the functions of a malformed body appendage, or to prevent or retard further deterioration of the patient's medical condition.

To qualify as a covered expense, the DME item must meet all of the following:

- Made to withstand repeated use
- Used mainly for a medical purpose, not mainly for comfort or convenience
- Useful only if the patient is sick or injured
- Ordered and/or prescribed by a physician for use in the patient's home
- Related to the patient's physical disorder

Eligible Charge. See Covered Charges/Covered Expenses, page 2.

Emergency. A sudden, serious, and unexpected onset of a medical condition having symptoms so acute and of such severity as to require immediate medical attention to prevent permanent danger to one's health or other serious medical results, impairment to bodily function, or permanent lack of function of bodily organs or appendages. An emergency may or may not require hospital admission and treatment must be provided by a physician or surgeon.

Employee. Any regular full-time or regular part-time employee so classified by the Company for payroll purposes. (See "Retired Employee", page 6.)

ERISA. The Employee Retirement Income Security Act of 1974, as amended. This act provides protection and guarantees for employees and the beneficiaries of employees covered by certain group benefit plans.

Exclusion. Any service, supply, treatment, circumstance, or expense not covered by MAP.

Experimental or Investigative. A particular treatment, procedure, facility, equipment, drug/drug use, supply, or service is experimental or investigative unless it is an approved means of treatment and as effective as any alternative means of treatment as determined by:

- Medicare and
- Blue Cross and Blue Shield Association and
- Blue Cross and Blue Shield of Alabama

Extended Care/Skilled Nursing Facility. An institution that provides for intermediate skilled nursing care for

- Be provided for the diagnosis or direct care of the medical condition
- Be used in accordance with standards of good medical practice accepted by the organized medical community
- Not be solely for the convenience of the patient, his/her family, his/her physician, or another provider of services
- Not be experimental or investigative
- Be performed in the appropriate medical setting to meet the patient's condition.

Medicare. A program sponsored by the Social Security Administration that provides medical benefits for certain individuals age 65 and older, and for certain disabled people under age 65.

Nurse Midwife. A person who is certified by the American College of Midwives or licensed/certified as a nurse midwife in the states requiring such license or certification. To be eligible for reimbursement under MAP, nurse midwife services must be pre-certified by QCP (see Section 6).

Occupational Illness or Injury. Expenses due to an occupational illness or injury covered by Workers' Compensation are not covered by MAP. However, PPO providers who have agreed to provide services for occupational illness or injury will be reimbursed at 100% of the PPO negotiable fees. All other providers of services related to occupational illness or injury will be reimbursed according to applicable state Workers' Compensation laws.

Out-of-Pocket Limit. See pages 15-16.

Partial Hospitalization. When a patient is admitted to the hospital under an approved treatment or rehabilitation program for substance abuse, and the daily stay is for less than 24 hours. To be eligible for reimbursement under MAP, Partial Hospitalization must be pre-certified by QCP (see Section 6).

Participants. The following individuals are Plan participants:

- Active regular employees and their enrolled dependents
- Regular employees on an approved Leave of Absence (other than a military leave) and their enrolled dependents
- Former regular employees who retire with a service or disability pension and their enrolled dependents
- Former regular employees who are LTD-eligible and not eligible for a disability or service pension and their enrolled dependents
- Surviving spouses of deceased employees/retirees and their enrolled dependents
- Former regular employees on technological displacement or layoff with extended medical coverage and their enrolled dependents
- COBRA-covered individuals and their enrolled dependents

Payment Allowance (PA). Limits established for determining non-PPO payments in each PPO area which are based on the negotiated fees charged to BellSouth by the PPO providers (e.g., hospitals and physicians) within that area. Amounts over the PA are not covered by MAP.

Pre-Existing Condition. See page 16.

Preferred Provider Organization (PPO). A hospital, physician or pharmacy that contracts with BellSouth to provide medical services to BellSouth participants at contracted fees.

PPO Area. A geographic area that contains a network of hospitals and physicians who have agreed to provide medical services to BellSouth participants for contracted fees. You live in a PPO area if your residence Zip Code is within 25 aerial miles of any PPO hospital. QCP can tell you if you live in a PPO area.

If you live in a PPO area and Medicare is not your primary plan, you are subject to MAP's PPO provisions for obtaining maximum Plan payments, whether or not MAP is your primary plan.

Private Duty Nursing. Professional services provided by a registered nurse (RN) or a licensed practical nurse (LPN) are covered by the Plan when these services require the special knowledge and skill of a trained professional nurse. To be eligible for reimbursement under MAP, private duty nursing care must be pre-certified by QCP. Custodial/routine patient care or care that is provided by a non-professional individual is not covered under MAP.

Provider of Treatment. An individual who is licensed to prescribe and administer drugs or to perform surgery. Under MAP, this includes the following: Physicians, Surgeons, Chiropractors, Dentists, and Podiatrists who practice within the scope of their licenses. (Emergency medical care related to an accidental injury or sudden and serious illness must be provided by a medical doctor (M.D.), or surgeon, or dentist to qualify for reimbursement under MAP.)

"Physician" also means an individual who possesses a Doctorate degree (Ph.D, Psy.D or Ed.D) and who is licensed as a clinical psychologist and provides psychological services in connection with the diagnosis or treatment of a mental/nervous condition. To be eligible for reimbursement under MAP, these inpatient services must be pre-certified by QCP. Services provided by a social worker or counselor are not covered under MAP.

Quality Care Program (QCP). A feature of MAP designed to assist you in your selection of appropriate medical care and the avoidance of unnecessary medical expense. QCP is administered by United HealthCare, Inc.

QCP Penalty. If a participant fails to follow the QCP process or fails to follow the QCP recommendations, MAP payments are reduced by $250 for each failure to comply. The QCP penalty does not apply toward the MAP deductible or the out-of-pocket limit.

Reasonable And Customary (R&C). The fair and reasonable value of a medical procedure or service based on historical data developed from the following criteria.

A charge is "reasonable and customary" when:

- The fee is that which an individual physician or provider of medical service most frequently charges to the majority of patients for a similar service or medical procedure and which falls within the range of usual fees charged for that service by physicians or other medical providers with similar training and experience for the performance of similar services or medical procedures within the same locality, OR
- Blue Cross and Blue Shield determines if the fees are justified because of special circumstances, or medical complications requiring additional time, skill and experience in connection with a particular service or procedure.

Reasonable and customary charges for physicians and other covered medical services, for other than services provided by hospitals, will be determined and maintained by Blue Cross and Blue Shield.

Retired Employee/Retiree. A former employee who was granted a service or disability pension by the Company pursuant to a BellSouth Corporation Pension Plan. (A former employee who is eligible for or receives a deferred vested pension is not considered a retired employee.)

Review. A request for review of any denied claim (either in whole or in part) or other disputed matter. You, your dependent, or a duly authorized person must submit the request for review within 180 days of receipt of notification of the denied benefits or other disputed matter.

Second Surgical Opinion. An independent physician's review of a patient's condition and recommended surgical treatment (see Section 8).

Subrogation. Allows the Claims Administrator the right to recover benefits paid to a Participant from a third party whose negligent or wrongful actions caused illness or injury to a Participant. The Claims Administrator may assert this right directly against the third party or against any recovery that a participant has received from the third party.

For example, if you are injured in an automobile accident and the other driver is at fault, MAP will provide benefits for covered services related to the accident. However, the Claims Administrator has the right to recover any MAP payment amounts from the third party (e.g., automobile insurance).

SECTION 2. ELIGIBILITY

ACTIVE EMPLOYEES

As a regular full-time or regular part-time employee of the Company, you are eligible to participate in MAP. Your dependents are also eligible for coverage as long as you enroll them, and they qualify as dependents (as defined in Section 1).

RETIRED EMPLOYEES

As a retired employee, you are eligible to participate in MAP. Your dependents are also eligible for coverage as long as you enroll them, and they qualify as dependents (as defined in Section 1).

HOW TO ENROLL/CHANGE ENROLLMENT

If you are employed or retired from:

- BellSouth Enterprises, Inc.
- BellSouth Financial Services Corporation
- BellSouth Information Systems, Inc.
- BellSouth Mobility, Inc.
- Intelligent Media Services, Inc.
- BellSouth Advertising & Publishing Corporation
- BellSouth International, Inc.
- BellSouth Resources, Inc.
- SunLink Corporation
- Intelligent Messaging Services, Inc.

. . . you must complete an Enrollment Form and forward it to the appropriate Benefit Office when enrolling or making changes in your enrollment status for you and your dependents.

If you are employed or retired from:

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth Communication Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Telecommunications, Inc.

. . . you can enroll in MAP or make changes to your enrollment by calling the Active or Retiree Benefit Office. See pages 60-61 for telephone numbers.

Please have the following information available when you call:

- Social Security number(s) for you and any dependents you are enrolling (If you are enrolling a newborn child, the social security number may be provided later.)
- Birthdates for any dependents you are enrolling
- Your dependents' addresses, if different
- The name, address, and policy number of any other insurance (including Medicare) for you or your dependents, if applicable
- For working spouses, date employed and number of hours he/she works per week

When changes are made, active employees will receive a confirmation letter through Company mail. The Active Benefit Office, located in Birmingham, records all calls for accuracy and verification.

Note: No one can be enrolled as a covered employee/retiree and a covered dependent at the same time. In addition, no one can be enrolled and covered as a dependent of more than one employee/ retiree at the same time.

DISABLED CHILDREN CERTIFICATION REQUIREMENTS

A disabled dependent must be certified through your Benefit Office. The Company may request recertification of disability or incapacitated status. A Disabled Dependent Eligibility Request Form may be obtained by contacting your Benefit Office.

SPOUSES EMPLOYED BY THE SAME BELLSOUTH COMPANY

If you and your spouse are employees of the same Participating Company, you are both eligible for coverage under MAP, and you have three options:

- You and your spouse each may be covered as an employee. Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same day of the same month, your dependents must be enrolled with the older spouse;
- You may waive employee coverage and be enrolled as a dependent under your spouse's coverage; or
- Your spouse may waive employee coverage and be enrolled as a dependent under your coverage.

SPOUSES EMPLOYED BY DIFFERENT BELLSOUTH COMPANIES

If you and your spouse are employees of different Participating Companies and you are both eligible for coverage under MAP, you and your spouse may not waive coverage as an employee.

Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same day of the same month, your dependents must be enrolled with the older spouse.

SPOUSE(S) RETIRED FROM BELLSOUTH COMPANIES

If you and your spouse are both retired employees of a Participating Company, but one of you has to pay for coverage, the one who must pay may waive coverage as a retired employee and be covered by the other as a dependent.

If you are retired, and your spouse is an active employee of a Participating Company, you may waive retiree coverage and be covered as a dependent of your spouse.

SECTION 3. WHEN COVERAGE STARTS

BEFORE SIX MONTHS OF SERVICE

If you are a new regular full-time or regular part-time employee, you may enroll for individual or dependent coverage within 31 days of your date of hire by calling the Benefit Office and by paying the full cost of coverage. (See Section 2, HOW TO ENROLL/CHANGE ENROLLMENT.) If you elect to pay, coverage will be effective on the first day of the month after your call.

FOLLOWING SIX MONTHS OF SERVICE

If you did not enroll within 31 days from your date of hire, coverage will begin automatically on the day you complete six months of Net Credited Service as a regular full-time employee or a regular part-time employee who works:

- 25 or more hours a week (if hired after December 30, 1980, but prior to January 1, 1990) **or**
- 37.5 or more hours a week (if hired on or after January 1, 1990).

If you are a regular part-time employee whose coverage is not fully and automatically provided by the Company based on hours worked (as explained above) and you did not enroll for coverage within 31 days of your date of hire, you may elect to pay for coverage after completing six months of service. Coverage will be effective on the first day of the month following the date you call the Benefit Office to enroll.

SECTION 4. COST

EMPLOYEES AND CLASS I DEPENDENTS

Full-Time Employees

The Company pays the full cost of coverage for you, your spouse, and other Class I dependents beginning on the date you complete six months of Net Credited Service. If you want coverage prior to that time, you must pay the full cost.

Part-Time Employees

If you are hired or re-engaged after a service break on or after January 1, 1990, you will be required to pay a portion of the cost of your medical coverage for any periods during which you are classified as a regular part-time employee and during which you work less than 37.5 hours per week. The amount you will be required to pay will be based on the percentage of hours you worked compared to a 37.5-hour work week.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week), then you work 60% of a 37.5-hour work week, the Company will pay 60% of the cost of your coverage–individual, two-party, or family. You will be required to pay the remaining 40% of the cost.

If you were hired after December 31, 1980, and were on the payroll on December 31, 1989, as long as you remain continuously employed thereafter (no service break), your weekly cost for periods in which you are classified as a regular part-time employee will be the lesser of the cost in effect on January 1, 1990, and the cost in effect for the period from December 31, 1980, through December 31, 1989.

As information, the percentage paid by the Company for employees hired during the period from 1981 through 1989 was based on the following schedule:

Your Weekly Work Schedule	Cost Paid By BellSouth
< 16 hours	0%
16-24 hours	50%
> 24 hours	100%

If you were hired prior to January 1, 1981, no contribution is required as long as you were classified as a regular part-time employee after December 31, 1989, and your period of work has been continuous (no service break) since December 31, 1980.

Employees On Leave Of Absence

Employees on an approved Leave of Absence in excess of one month (other than a Military Leave) must pay the full cost if coverage is desired.

Employees On Sabbatical Leave Of Absence

The Company will continue to provide coverage for employees on an approved Sabbatical Leave of Absence. Coverage may be continued for Class II and Sponsored Dependents by continuing to pay the premiums in a timely manner.

Employees On Military Leave

Coverage for employees on approved Military Leave ends on the first day of the month following the beginning of the Leave. However, dependent coverage may be continued under COBRA (see Section 15).

Employees On Care Of A Newborn Child (CNC) Or Dependent Care Leaves

If the leave is an approved CNC Leave or a Dependent Care Leave, the Company will pay the full cost of coverage for up to six months during the leave in any 2-year period, provided you were eligible to receive Company-paid coverage prior to the leave.

RETIREES AND CLASS I DEPENDENTS

Service Or Disability Pension Effective Prior To January 1, 1988

The cost of coverage for you, your spouse, and your other Class I dependents whose coverage began prior to January 1, 1988, is paid in full by the Company. However, you must pay the full cost of coverage for your Class I dependents, other than your spouse, added on or after January 1, 1988. The cost of coverage for a spouse added after January 1, 1988, is paid in full by the Company.

Service Or Disability Pension Effective On Or After January 1, 1988, But Before January 1, 1992

The cost of coverage for you, your spouse, and your other Class I dependents whose coverage began before your retirement effective date is a percentage based on your years of employment, as shown in the following chart:

Years Of Employment	% Of Cost BellSouth Pays	% Of Cost You Pay
≥ 30	100%	0%
20-29	90%	10%
15-19	80%	20%
< 15	70%	30%

If you retired on or after January 1, 1988, you must pay the full cost of coverage for your Class I dependents, other than your spouse, added on or after your retirement. The cost of coverage for a spouse added after you retire is the same as the cost of your coverage (see chart above). You are not required to pay the prorated premium if you retire under an early retirement program that waives the premium; i.e., VEER/VEER '91.

Service Or Disability Pension Effective On Or After January 1, 1992

The cost of coverage for you, your spouse, and other Class I dependents whose coverage began before your retirement will be paid by the Company beginning in 1993 and each year thereafter, up to the 1990 actual cost level.

Beginning in 1993, your share of the cost for that year and each year thereafter will be the excess of the annual cost for the year two years prior to 1993 and each year thereafter over the 1990 cost plus the proration of the 1990 cost based on your years of employment.

For example, the annual cost in 1993 would be determined by subtracting the 1990 cost from the 1991 cost. The 1994 cost would be determined by subtracting the 1990 cost from the 1992 cost. This is in addition to the proration of the 1990 cost, based on your years of employment.

Retirement Under The Supplemental Income Protection Plan On Or After January 1, 1990

If you retire under a formal surplus force-reduction program, presently known as the Supplemental Income Protection Plan (SIPP), or any successor plan, and have less than 30 years of service, you will not be required to pay the prorated percentage of the chart above. You must pay the full cost of coverage for Class I dependents, except your spouse, added after the effective date of your retirement. The cost of coverage for your spouse added after retirement is paid in full by the Company. However, if you retire under SIPP on or after January 1, 1992, you will have to pay the premium associated with the increase in cost above the 1990 level.

CLASS II DEPENDENTS

The cost of coverage for Class II dependents enrolled on or before January 1, 1988, is 50% of the total cost of coverage for a Class II dependent.

The cost of coverage for Class II dependents enrolled after January 1, 1988, and for Class I dependents reclassified as Class II dependents after January 1, 1988, will be the total cost of coverage for a Class II dependent. Contact your Benefit Office for the rates.

SPONSORED CHILDREN

You pay the full cost of coverage for these dependents. Contact your Benefit Office for the rates.

PAYING FOR COVERAGE

If you pay for coverage, payments are made as follows:

- Active employees pay through payroll allotments.
- Retired employees pay through pension allotments.
- Retired employees who elected a lump-sum option in lieu of a monthly pension pay directly to Blue Cross and Blue Shield of Alabama.
- Direct bill participants, such as COBRA-covered individuals, surviving spouses, extended medical participants, etc., pay directly to Blue Cross and Blue Shield of Alabama.
- LTD non-pension eligibles pay directly to Blue Cross and Blue Shield of Alabama.

SECTION 5. HOW MAP WORKS

WHEN REVIEWING YOUR MAP BENEFITS, PLEASE REMEMBER:

- Most MAP provisions (e.g., PPO hospital requirements) apply whether MAP is the primary or secondary plan.
- If MAP is your primary plan, pre-certification through QCP is required for all inpatient admissions.
- Whether MAP is your primary or secondary plan, pre-certification is required for all mental/nervous admissions as well as for services considered to be Alternate Benefits.
- PPO provisions affect MAP benefit levels (see Sections 7, 8, and 9).
- MAP is designed to cover medical treatment for illness. Routine checkups are not covered, except for certain mammograms, pap smears, and well child care, specifically identified under MAP.
- Although MAP covers many services, certain items and services are not covered (see Section 11).
- MAP covers licensed physicians and some other providers of service. However, not all providers are eligible for coverage (see Section 8).
- You have several options when purchasing prescription drugs. If your physician allows generic substitution, you can maximize your benefits by choosing a generic.
- If you or your dependents become eligible for other insurance coverage, MAP benefits will be affected whether or not you enroll with the other option.

OVERVIEW

MAP pays a specified percentage of covered charges, and you pay the remainder of the expenses. However, for some expenses, you must first satisfy the deductible before MAP begins paying benefits.

The percentage of covered charges MAP pays depends on the way you use the Plan. To receive maximum MAP benefits, you must:

- Comply with QCP requirements (see Section 6)
- Use PPO hospitals and physicians when they are available
- Use other cost-effective Plan features (such as outpatient surgery)

A PPO network includes hospitals, pharmacies, and physicians who contract with BellSouth to provide medical services at negotiated fees. QCP can tell you whether or not you live in a PPO area (defined on page 6). If you do, QCP can provide you with the names of the PPO hospitals and physicians in your area.

MAP features that can minimize your out-of-pocket expenses are explained throughout this booklet. They include, but are not limited to, receiving medical care where appropriate (such as having minor surgery performed on an outpatient basis rather than inpatient) and obtaining a confirming second surgical opinion when required. The following Sections explain in more detail how these various features can affect your benefit payments.

COVERED CHARGES

Covered charges (defined on page 2) are medically necessary expenses incurred for the treatment of a non-occupational illness or injury. Following are some of the services and expenses covered under MAP:

- Hospital care
- Outpatient care
- Physician/Surgeon care

- Prescription drugs
- Certain charges for DME

Periodically there may be changes in the coverage provided by MAP. Benefits will be determined by the provision in effect at the time the services are provided.

Covered charges are explained in greater detail in Sections 6-11.

INDIVIDUAL DEDUCTIBLE

In most cases, you pay the first $165 of covered expenses for yourself and each dependent each calendar year before MAP begins to pay benefits. Once the deductible requirement has been satisfied, MAP will pay a percentage of covered charges–generally 90%. However, the deductible is not applicable when you take advantage of certain cost-saving Plan incentives, such as obtaining services through a PPO physician.

The deductible must be met each calendar year from that year's covered expenses.

FAMILY DEDUCTIBLE

Under MAP your family deductible will be met each calendar year on the earlier of the date when:

- Covered charges applied toward your deductible and/or other family members' individual deductibles total $400, or
- Two $165 individual deductibles have been met.

The deductible will be applied to your claims in the order in which claims are processed by the Claims Administrator, regardless of the order in which they are received.

Once the family deductible is met, no additional covered expenses are applied toward any family member's individual deductible for the rest of the calendar year, even if you and your spouse are employees of different BellSouth Participating Companies. MAP then considers any future claims that year as if each family member has satisfied the individual deductible requirement.

For example, suppose you submitted $65 in covered charges which applied toward your individual deductible. In addition, you submitted covered charges totaling $150 for your son, $100 for your daughter, and $85 for your spouse–all of which applied toward each person's deductible.

Since the amounts applied toward individual deductibles total $400, the family deductible has been satisfied. This means that each family member's covered charges for the balance of the year will be processed, and benefits will be paid as if each had satisfied his/her individual deductible requirement. Also, the family deductible would be met if your son and daughter each met the $165 individual deductible.

INDIVIDUAL OUT-OF-POCKET LIMIT

FAMILY OUT-OF-POCKET LIMIT

Once two family members each reach their individual out-of-pocket limits, even if you and your spouse are employees of different BellSouth Participating Companies, MAP pays benefits as though each covered family member has reached that limit.

EXPENSES THAT DO NOT APPLY TO THE OUT-OF-POCKET LIMIT

Some expenses do not apply toward reaching the out-of-pocket limit. These include, but are not limited to:

- The $165 individual deductible or $400 family deductible
- Expenses not covered under MAP, such as the Alternate Benefits (see page 19) and inpatient expenses due to mental/nervous conditions when those expenses are not pre-certified by QCP
- Expenses incurred due to pre-existing conditions
- Expenses not medically necessary
- Copayments, such as those for the Mail Order Prescription Drug Program, PPO pharmacy, PPO physicians (office visit only), and non-emergency conditions
- Covered charges not paid by MAP because of COB rules (see Section 12)
- Expenses above MAP coverage limits, such as the maximum benefit limit of $150,000 for treatment of mental/nervous conditions
- Expenses above the benefits paid by MAP for inpatient mental/nervous care (see Section 9)
- Expenses above the benefits paid by MAP for outpatient mental/nervous care
- Expenses above R&C or PA limits, where applicable
- The QCP penalty
- Expenses above the benefits paid by MAP for Chiropractic services

PRE-EXISTING CONDITION PROVISION

Expenses incurred due to a pre-existing condition are not covered by MAP.

A pre-existing condition is an illness, injury, or condition, including pregnancy, for which you or a dependent received treatment (including, but not limited to, medication) during the 90 days prior to the effective date of coverage.

An illness or injury is no longer considered a pre-existing condition under MAP when:

- No treatments have been received for the pre-existing condition during six consecutive months of coverage under MAP, **or**
- MAP coverage on the participant with the pre-existing condition has been in effect for 12 months.

THE HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

Each year you will be given the choice to continue coverage under MAP or to elect coverage through an HMO, approved and offered by the Company in the area in which you live.

You may also enroll in an HMO within 31 days of:

- Your initial employment or reinstatement to active employment,
- The date you move into a new HMO service area, **or**
- Your pension effective date.

In addition, your eligible dependents may enroll or re-enroll in an HMO (according to that HMO's rules) as long as you are enrolled in that HMO.

If an HMO is available to you, and you elect it as your option, the Company contributes up to the same amount it would pay toward the cost of MAP coverage. You pay any additional costs (based on the enrollment costs established by that HMO) through payroll or pension allotments.

MAP LIFETIME BENEFIT MAXIMUM

Generally, while you are an active employee, there is no overall lifetime benefit maximum to the amount of benefits payable under MAP for you or your dependents. However, certain benefits, such as for mental/nervous care, have specific limits as described throughout this booklet.

A $1,000,000 individual lifetime benefit maximum applies to:

- Retirees and their dependents, for expenses incurred on or after the first day of the year following retirement.
- LTD-eligibles and their enrolled dependents, for expenses incurred on or after the first day of the year following eligibility for LTD benefits.
- Dependents of deceased active employees with surviving spouse benefits for expenses incurred on or after the first day of the year following the date each surviving dependent (including the spouse) reaches age 65.

SECTION 6. THE QUALITY CARE PROGRAM (QCP)

QCP, administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care. QCP provides you with information that allows you, in consultation with your physician, to evaluate medically appropriate alternatives to surgery and hospitalization. In addition, QCP monitors any certified hospital confinement and keeps you informed as to whether or not the stay remains certified under MAP.

QCP also helps by advising you if your maternity charges or other surgeon's charges are within MAP's coverage limits. For QCP to do this, QCP must be provided the physician's Current Procedural Terminology (CPT) code.

* * * * * *

Remember, all decisions regarding your medical care are up to you and your physician.

* * * * * *

HOW TO CONTACT QCP

Call QCP toll free at **1-800-541-2234**. It is your responsibility to ensure QCP is contacted. To save time, it is recommended that your physician contact QCP; however, a family member or a friend may call QCP on your behalf.

WHEN TO CALL QCP

There are certain circumstances when QCP must be contacted if you are to receive maximum MAP benefits as explained below.

When MAP is the primary plan, QCP pre-certification is required for:

- Inpatient hospital admissions, including all maternity admissions
- Mandatory Outpatient Surgical Procedures performed on an inpatient basis (see page 27)
- Surgical procedures on the Mandatory Second Surgical Opinion List (see page 28)

QCP certification is required within 48 hours of any emergency hospital admission if the stay is expected to last longer than 48 hours. QCP certification is not required for surgery or hospitalization outside the continental United States.

In order to be covered, QCP pre-certification is always required for all inpatient mental/nervous care expenses and alternate benefits (see page 29) whether MAP is the primary or secondary plan, even if you or your dependents are Medicare-primary. Rules for determining when MAP is the primary or secondary plan are explained in Section 12.

The pre-certification provided in no way represents a guarantee of payment. Benefits for any claim will be provided according to the eligibility, terms and conditions of the participant's contract at the time service is rendered.

You may also contact QCP if you need to know whether or not your physician or hospital is a PPO provider.

NOT CONTACTING OR COMPLYING WITH QCP

The QCP Penalty applies when MAP is the primary medical plan, and QCP is not contacted or does not certify:

- Overnight hospital admissions (including emergency admissions that last longer than 48 hours)

- Inpatient surgeries
- Mandatory Outpatient Procedures performed on an inpatient basis
- Surgeries on the Mandatory Second Surgical Opinion List
- Maternity admissions

In other words, if you do not contact QCP or do not follow QCP's recommendations, your MAP payments will be reduced by $250 for each failure to comply. Therefore, more than one QCP Penalty may be applied for a single hospital confinement. QCP Penalties do not apply toward the deductible or out-of-pocket limit.

Whether MAP is your primary or secondary medical plan, and whether or not you or your dependents are Medicare primary, QCP pre-certification is always required for coverage for Alternate Benefits and Inpatient Mental/Nervous Care; otherwise, there is **no coverage** for these expenses, and they will not apply to the deductible or out-of-pocket limit.

* * * * * *

Remember, all decisions regarding your medical care are up to you and your physician.

* * * * * *

ALTERNATE BENEFITS

Alternate Benefits provide options to hospital stays and other medical care or treatments and must be pre-certified by QCP. The following coverage is included:

- Home health care
- Extended care/skilled nursing facilities
- Birthing centers/nurse midwives
- Hospice care
- Partial hospitalization for a substance abuse rehabilitation program (see page 30)
- Expenses due to special arrangements or treatments when medically appropriate
- Private duty nursing

If pre-certified by QCP, once you have met the deductible, 100% of the covered charges for Alternate Benefits will be paid by the Plan, except private duty nursing which is paid at 90% of the covered charges.

If not pre-certified by QCP, the Alternate Benefits are not considered covered expenses; therefore, they are not eligible for reimbursement under MAP. However, the decision to use an Alternate Benefit is up to you and your physician.

INPATIENT MENTAL AND NERVOUS CARE

Benefits for inpatient mental/nervous care, including substance abuse care are eligible for reimbursement under MAP only if pre-certified by QCP. Pre-certification is required regardless of whether MAP is the primary or secondary plan, including Medicare-primary participants.

If QCP does not pre-certify an inpatient stay for mental/nervous treatment, the expenses are not covered by MAP; therefore, they are not eligible for reimbursement. However, the decision to use inpatient treatment for mental/nervous care is up to you and your physician.

Mental/nervous confinements will be reviewed periodically during the hospitalization to determine the portion of care that is medically necessary treatment versus that which is maintenance or custodial and not covered under MAP. The Plan's specific benefit levels for mental/nervous care are explained in Section 9.

EMERGENCIES

In an emergency, QCP must be contacted within 48 hours if you are admitted to the hospital and not released in 48 hours. If you are admitted to a non-PPO hospital but live in a PPO area, QCP, with your physician's input, will determine if a transfer to a PPO hospital is possible. If it is determined that a transfer is possible, and you choose not to move, benefits will be reduced. When transfer arrangements are handled by QCP, MAP pays the full cost of the transfer. Maternity admissions are not considered emergencies and must be pre-certified by QCP.

* * * * * *

The decision to remain in the non-PPO hospital and pay the associated costs or to move to a PPO hospital is yours to make in consultation with your physician.

* * * * * *

SECTION 7. HOSPITAL CARE BENEFITS

This Section outlines the most common hospital care expenses covered under MAP and the associated benefits. If you have questions about hospital expenses not listed here, call QCP or Blue Cross and Blue Shield of Alabama before proceeding with treatment to determine if the charges will be covered.

INPATIENT HOSPITAL BENEFITS

MAP covers expenses for medically necessary hospital services. The amount MAP pays is determined by whether or not you:

- Live in a PPO area
- Use a PPO hospital, even if MAP is the secondary plan
- Are a Medicare-primary participant

Covered hospital services include:

- Semi-private room and board
- Private room when in a private-room-only hospital (90% of the most prevalent private room rate)
- Use of operating, delivery, and recovery rooms plus special equipment
- General nursing care
- Laboratory tests and X-rays
- Special diets
- Physical therapy
- Administration of blood (See page 38 for benefits for the cost of the blood.)

QCP can give you PPO hospital telephone numbers so you can call and ask for the names of physicians with admitting privileges. If a PPO physician network has been established in your area, QCP can provide the names of participating physicians. **For maximum MAP benefits, you must follow the Plan's QCP provisions described in Section 6.**

BENEFITS WHEN YOU AND/OR A DEPENDENT ARE MEDICARE-ELIGIBLE AND MEDICARE IS PRIMARY

After the deductible is met, MAP pays 100% of covered inpatient hospital charges, less the amount eligible for Medicare payment (and/or any other coverage that is primary to MAP, as explained in Section 12). MAP's PPO hospital provisions do not affect you.

BENEFITS WHEN MAP IS PRIMARY

After the deductible is met, MAP pays inpatient hospital benefits for covered hospital charges, as follows:

- PPO hospital charges are paid at 100% of inpatient covered charges.
- If you live in a PPO area, non-PPO hospital benefits are paid at 90% of the PPO area PA for covered inpatient hospital charges. Any charges above the PPO area PA are not covered expenses and do not count toward your deductible or individual out-of-pocket limit. **Therefore, the amount you pay could be 40% or more of the non-PPO hospital charges.**
- If you do not live in a PPO area, MAP pays 100% of covered charges.